CCBHC Planning Grant

Frequently Asked Questions

February 26, 2016

	Question	Response
1.	If Nevada is not chosen as a demonstration site, does the State of Nevada anticipate continuing to move forward with the model to help ensure that agencies have an outcome for their hard work at setting up their practice models?	Nevada will move forward with CCBHC planning as a state if not awarded the Demonstration Program grant. We will have additional details on this approach as we proceed through the planning process.
2.	Will there be any additional opportunities for get questions answered or other technical assistance if the need arises during the application preparation process?	Technical assistance is available during different phases of the planning grant. One phase is during the RFA process and another phase will be after the state selects potential CCBHCs to proceed with the certification process. Responses to questions submitted in accordance with the RFA criteria are available at http://dpbh.nv.gov/reg/ccbhc/ccbhs-main/ In addition, a technical assistance call related to RFA submission was held on February 19, 2016. Minutes of that call are available at http://dpbh.nv.gov/reg/ccbhc/ccbhs-main/ In addition, a general one hour educational webinar related to CCBHC planning grant activities is scheduled to be presented at two different times. The anticipated dates are March 2, 2016 at 3:00 PST and March 4, 2016 at 8:30 a.m. PST. However, these dates are subject to change. Please check daily http://dpbh.nv.gov/reg/ccbhc/ccbhs-main/ for the most up-to-date information. Further, during the certification phase of the planning grant the state will assess the technical assistance needs of prospective CCBHCs and develop a focused strategy for providing technical assistance at that time.

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3.	Which tools will be required for the preliminary screening and risk assessments?	The expectation is that evidence based practices, best practices, and tools which meet standards of behavioral health practice and medical practice will be utilized when performing preliminary screening and risk assessments of patients. The state is currently reviewing evidence based practices and will provide further guidance at a later date.
4.	What are the components of the required continuous quality improvement plan?	The Continuous Quality Improvement (CQI) plan will vary by CCBHC based on the needs of the CCBHC's population. The plan components should focus on improvement in CCBHC performance and it should reflect the scope, complexity and past performance of the CCBHC services and operations. The CQI plan is to be developed by the CCBHC and reviewed and approved by the state during certification. Specific events expected to be addressed as part of the CQI include: (1) CCBHC consumer suicide deaths or suicide attempts; (2) CCBHC consumer 30 day hospital readmissions for psychiatric or substance use reasons; and (3) such other events the state or applicable accreditation bodies may deem appropriate for examination and remediation as part of a CQI plan.
5.	Can a private, for-profit organization become a CCBHC?	No, a private, for-profit organization is not eligible to be a CCBHC.
6.	Which CCPPS rate methodology will Nevada use? CCPPS-1 or CCPPS-2?	Nevada selected the CCPPS-1 methodology.

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7.	When determining the PPS, what are the direct and non-direct costs that will be considered? Please list.	Direct costs attributable to CCBHC services may include: CCBHC health care staff costs (compensation), costs of services under agreement with DCOs, medical supplies, professional liability insurance, telehealth costs, and medical equipment depreciation. Indirect costs attributable to CCBHC services may include: rent, insurance, utilities, administrative office salaries, office supplies, professional services (i.e., legal, accounting, etc.), phone/internet, building depreciation, housekeeping, and maintenance. Please reference the CCBHC cost report template and instructions at the following link for further guidance on CCBHC direct and indirect cost allocations: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/financing-and-reimbursement/223-demonstration-for-ccbhc.html
8.	Which overhead costs are to be excluded?	Indirect costs (listed above) attributable to non-CCBHC services. Please reference the CCBHC cost report template and instructions at the following link for further guidance on CCBHC direct and indirect cost allocations: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/financing-and-reimbursement/223-demonstration-for-ccbhc.html
9.	I have a question regarding a CCBHC applicant and a DCO applicant. We are a small agency, Medicaid provider Type 14, who is a Nevada Medicaid provider for recipients with Full Fee Medicaid. We have been in business since March 2013, my question is, as a Medicaid provider does that consider us a "CCBHC" applicant or do we fall under the DCO applicant status. We are for profit so I am just wondering.	See the response to Question 24 for CCBHCs. For profit DCOs are eligible to contract with CCBHCs.

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10.	Can a CCBHC limit the client population to serious mentally ill individuals 18 years of age or older? Child/adolescent services are very limited in our area.	According to the Substance Abuse and Mental Health Services Administration (SAMHSA), target populations for CCBHCs are adults with SMI, children with SED, those with long term and serious SUD, and others with mental illness and SUD. Section 223(a)(2)(D) of PAMA states provision of services, if not available directly through the certified community behavioral health clinic, are provided or referred through formal relationships with other providers. CCBHCs are required to maintain a core staff comprised of employed and, as needed, contracted staff, as appropriate to meet the needs of the CCBHC consumers as stated in consumers' individual treatment plans. If a CCBHC is not able to provide the required services, the certification criteria permit the CCBHC to partner with a Designated Collaborating Organization (DCO). Additional information regarding DCOs is available on the SAMHSA website. www.samhsa.gov/section-223/care-coordination/designated-collaborating-organization
11.	Can we use a Case Manager for the 24 hour access requirement or is there a requirement that a psychiatrist be available to provide this level of access?	All CCBHC providers who furnish services directly, and any Designated Collaborating Organization (DCO) providers that furnish services under arrangement with the CCBHC are legally authorized in accordance with federal, state and local laws, and act only within the scope of their respective state licenses, certifications, or registrations and in accordance with all applicable laws and regulations. According to the certification criteria, a CCBHC provides crisis management services that are available and accessible 24-hours a day and delivered within three hours. The certification criteria require CCBHCs to clearly describe in their policies and procedures the methods for providing a continuum of crisis prevention, response, and prevention services and these policies should be made available to the public.

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12.	Psychiatric access may be limited to several half-days during the week. Is that acceptable?	As part of the process leading to certification, the state will prepare an assessment of the needs of the target consumer population and a staffing plan for prospective CCBHCs. The needs assessment will inform the staffing for the CCBHC.
13.	Are there specific CCBHC clinic hours that must be maintained during the week?	As part of the process leading to certification, the state will prepare an assessment of the needs of the target consumer population. The CCBHC will provide outpatient clinical services during times that ensure accessibility and meet the needs of the consumer population to be served.
14.	Can psychiatry residents be utilized to provide care and bill for services if CMS guidelines are followed? Likewise, can Family Medicine residents be utilized to provide primary care and bill for services if CMS guidelines are followed?	All CCBHC providers who furnish services directly, and any Designated Collaborating Organization (DCO) providers that furnish services under arrangement with the CCBHC are legally authorized in accordance with federal, state and local laws, and act only within the scope of their respective state licenses, certifications, or registrations and in accordance with all applicable laws and regulations.
15.	Can you please direct us to the specific cost principles that will be utilized in developing the Prospective Payment System rates for CCBHCs?	In reporting cost, the state and providers must adhere to 45 CFR 75 - Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards and 42 CFR 413 - Principles of Reasonable Cost Reimbursement.
16.	Are there any examples of rate ranges that other similar entities are paid under a PPS model?	The state is unable to provide a range at this time given that CCBHCs are a new program and provider type, consisting of varying, provider-specific cost and visit volumes that are currently unknown.

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17.	The guidance indicates that a CCBHC must service individuals regardless of ability to pay. However, many uninsured patients are unable to make even nominal payments toward their care. Many Federally-Qualified Health Centers receive section 330 grant support from HRSA for the uninsured, homeless and other uncompensated care patients. Is there a similar funding source available for CCBHCs to cover uncompensated care costs for patients unable to pay?	The state is unaware of federal CCBHC funding sources available to supplement uncompensated care costs and suggests that potential CCBHC providers contact HRSA or other applicable federal funding organizations to learn of such funding opportunities, as well as any impacts on current federal funding being received. The state is currently exploring funding options for CCBHC uncompensated care costs.
18.	Currently, one Medicaid managed care plan subcontracts behavioral health services to a separate behavioral health managed care organization. This entity employs its own therapists and clinicians and only occasionally credentials community providers as a part of their network. Even if credentialed, the ability of community providers is limited to assessments and a few sessions before the patient is required to see their own employed therapists. This model presents a barrier to the goals of integrated behavioral health and primary care, fundamental to the CCBHC as well as integrated Patient-Centered Medical Homes. Will Medicaid managed care contracts be amended to require the plans to support and contract with integrated care models in CCBHCs and other integrated care settings, like integrated PCMHs?	Nevada intends to amend the Managed Care Organization (MCO) contracts to require the inclusion of CCBHCs as safety net providers and to support the CCBHC model. Providers enrolling in the MCOs must complete the MCOs' credentialing and contracting process. Responses to RFA questions only address the CCBHC delivery model.
19.	Will CCBHCs and integrated PCMHs be allowed by Medicaid managed care plans to provide all necessary behavioral health services without unreasonable prior authorization requirements?	The standards for prior authorizations in effect at the time of service should be followed.
20.	Is the State considering adopting a standard approach to integrated care, in terms of billing and utilization management, by Fee-For-Service Medicaid as well as the Medicaid managed care organizations? Currently, the different requirements for the Fee-For-Service Medicaid and the State's Medicaid MCOs create additional administrative costs for providers of integrated care.	This issue is currently under review by the State CCBHC team and a response will be available upon completion of their review.

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21.	How will the Health Assessment and Behavioral Intervention (HABI) codes by paid using a PPS model?	CCBHCs will receive their PPS rate for Health Assessment and Behavioral Intervention services.
22.	Will case management be included as a billable service either as a PPS billable encounter or a separate payment?	CCBHC targeted case management services qualify as a PPS billable encounter.
23.	How will Medicare/Medicaid dual eligible be covered? Will Medicare pay a PPS rate to the CCBHC? If Medicare does not pay a rate comparable to the Medicaid PPS rate, will the CCBHC be able to bill Medicaid up to the PPS rate? Will the CCBHC have to do cross-over billing for QMBs and other dual eligibles?	This issue is currently under review by the State CCBHC team and a response will be available upon completion of their review.
24.	Will the Medicaid MCOs pay the full PPS encounter rate to the CCBHC or will the State Medicaid Agency administer a separate “wrap” payment system? This can sometimes lead to delays in payment of the full PPS rate.	This issue is currently under review by the State CCBHC team and a response will be available upon completion of their review.
25.	What specific planning activities will be funded for CCBHC awardees in Phase I?	The state is exploring funding opportunities and will make determinations based on need and availability of funding.